Wyoming Department of Health

Healthcare Financing Division
Wyoming Medicaid
122 West 25th Street, 4 West
Cheyenne, WY 82002
(307) 777-7531 • 866-571-0944
Fax (307) 777-6964 • www.health.wyo.gov

Michael A. Ceballos
Director

Mark Gordon
Governor

Rights and Responsibilities

By signing this notification, you state that you understand the following:

Release of Medical Records: I understand that the Wyoming Department of Health (WDH) must be able to obtain medical records from providers if necessary. My signature authorizes my medical provider to release any medical records to the WDH.

Social Security Numbers: I understand that I am being asked to provide a Social Security Number to verify any current Medicaid benefits and to check for duplication. Social Security Number is not a requirement to receiving Presumptive Eligibility.

My Civil Rights: I understand that the program this application is used for will not exclude, deny benefits to, or otherwise discriminate against any person on the grounds of race, color, religion, political belief, or on the basis of disability or age in admission to, participation in, or receipt of the services and benefits of this program. For further information about this policy contact: Wyoming Department of Health at (307)777-7531 or the Office of Civil Rights at (800) 368-1019.

Medical Support: I understand that if WDH pays for medical or other related services, they have the right to collect from a third person or from available insurance or from settlements for accidents or injuries. If I receive any medical reimbursement payments from insurance companies or other potentially liable third parties while I am enrolled in Medicaid, I must pay WDH back.

Required Signature

I certify that the information given on the application is true and correct. I also have read and understand the Rights and Responsibilities on this notification.

Please sign here _____ **Date** _____

Print Name_____

Applicant Name_____

If this is a telephonic application- By signing, you as the Qualified Provider/Hospital are attesting that you have read the Rights and Responsibilities to the applicant and that the applicant certifies that the information given on the application is true and correct.

Please sign here _____ **Date** _____

Qualified Provider Name_____

Applicant Name_____